Healing the Healer & Peer Support

A little thing that makes a big difference

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The Root of the Problem

The Totality Healthcare is Deeply Rooted in the Myth of Perfection

“Health care providers have generally ignored human performance studies, viewing them as being applicable to more mortal populations.”
Bill Bornstein, MD. Chief Quality Officer, Emory Hospital

When Bad Things

To Err is Human: Building a Safer Health System (1999) begins to define the US quality

HOW WE DEAL WITH ERROR AFFECTS PATIENT SAFETY…

AND IT AFFECTS THE RESILLIENCY OF THE INDIVIDUAL AND THE HEALTHCARE WORKFORCE!

Does this image make you nervous??

☐ Excellent
☐ Good
☒ Average
☐ Poor

Resiliency

The ability to bounce back, retain healthy shape & fx after being pulled, stretched, pressed, bent, etc.

- We have confused strength and resiliency
  - Strength: power to resist forces. The power to resist break. (Merriam-Webster).
  - Qualities: solidness, un-moveable, resistant, trying to resist.
- Resilience: to bounce back & recover quickly
  - Qualities: elasticity, stretching, “allowing”
  - Stretch and recover

The biggest obstacle to resiliency is PERFECTIONISM

Go big or go home!!!

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Is This You??

You know there is no use crying over spilt milk, but you do it anyway

Ruminating over ways things went wrong and could have been done better or why they were wrong

Are you secretly nostalgic for your school days?

Are you known to go on a rant or pitch a fit???

- "That's wrong with these people... Why can't they pull it together?"
- "I have to do it myself if I want it done right!"
- "I have to fix everything"

Are you a procrastinator??

"You take things so personally" "Your so sensitive"

- How much does it bother you when others don’t agree w/ your point of view or do things "your way" (the right way)?
- Are you compelled to defend & explain your position?
- Do you generally feel misunderstood?
Do you secretly take pleasure in someone else’s “failure”? 

Do you often have a guilty soul?

Perfectionism DOES NOT promote Resilience or error!

- Practitioners (perfectionists) who have trouble accepting error often deny, rationalize, and refuse to report error.
- Error and near misses are under reported & compromises pt. safety.
- Perfectionism is a strategy to avoid guilt, shame, judgement & isolation, but actually increases the experience.

What is Trauma??

1. A deeply distressing or disturbing experience. (noun)
2. physical injury. (noun)

TRAUMA

"Trauma is by definition unbearable." 
"Trauma robs you of the feeling you are in charge of yourself" Bessel Van Der Kolk

Brain basics

Left Brain

"RESPONDS"

Analytical
Logical
Sequential

It gives us vocabulary and "Do all the talking"
We use it to explain our experience, put it in order, and give it context.

Makes logical sense

Right Brain

"REACTS"

Remembers sound, touch, smell, emotion evoked from experience.

Emotional
Intuitive knowing
Gut instinct
Visual
Spacial
Tactual

"Carries the music of experience"

Singing, dancing, swearing, crying, laughing

FEELS LIKE INTUITIVE TRUTH
Your Brain on Trauma

- Increased activity in the R limbic System (R emotional brain)
  - R Amygdala specifically
  - Fear-center
  - Warns of impending danger and activates the stress physiologic response
  - Us of hyperarousal…increased BP, HR, sweat, oxygen uptake, etc.
  - Fight vs Flight
  - Activates Brodmann’s Area 19- Visual Cortex (R emotional brain)
    - Normally only captures initial images & sends out for interpretation.
    - However, reactivated w/ traumatic memories as if the event were occurring in real time.
- Deactivates Broca’s area (Left brain)
  - Speech center
  - Unable to translate feelings and perceptions into words.
  - Deactivated when ever a flashback or traumatic memory is activated.
  - Literally loose your words.

Trauma Activates the Right Brain and Deactivates the Left Brain

- Activating the Right Brain leaves the person…
  - Emotionally Reliving sights, sounds, and feelings of an event as if it is present time.
  - Reliving Cellurally as if occurring in present time (ANS hormonal response
    - BP, HR, sleep, appetite, anxiety, hyperarousal taking over brain.
  - Deactivating the Left Brain leaves the person…
  - Unable to translate feelings and perceptions into words.
  - Unable to organize the experience into logical and sequential context
  - Unable to determine what is happening present vs. past.
  - Both physiologically & emotionally
- This still happens decades later w/ remembered traumatic events
- When one side of the brain is shut down (even temp)…. It is disabling!!!

Adverse Childhood Experience Study (ACES)

- 17,421 participants
- White, middle class, well educated, financially secure w/ insurance
- Your relatives, neighbors, and co-workers

Is Trauma is a Tipping Point?

ACES Results

- “The impact on adult health is strong & cumulative”
  - Of the 2/3 (11,614) that responded w/ an ACE score of 1 or more.
  - 87% scored 2 or more, 17% scored 4 or higher
  - Correlated w/adult disease states such as Borderline PD, Ca Depression, Anxiety, obesity, addiction, heart dz, lung dz.

Second Victims

- Defined as people who are involved with a patient-related adverse event or medical error, and, as a result, experience emotional and sometimes physical distress” Wu, BMJ 2000

Characteristics of the phenomenon

- Often feel personally responsible for event or outcome
- Commonly feel as though they have failed the client
- Begin to 2nd-guess their skill & knowledge base
- Fear they have lost the trust of their peers
- Feel they “should not” be reacting or feeling the way they are
- “This should not be happening”
The Consensus

- 50% of all providers will experience the 2nd Victim Phenomenon
- Manifests as acute post-traumatic stress
- Burn-out is a common causing may to consider leaving
- Altered thought patterns lead to additional incidents
- Medical Professionals are RESISTANT to seeking professional support.
- When properly trained, Peers are an excellent source of support that can positively affect the impact of an event.
- Impacted provider’s prefer peer support

The Relationship to Burnout

- Distressed medical providers make more errors
- Display risker work behavior profiles
- Making decisions to make things more manageable
- Display less empathy & compassion
- Tend to change specialties, decrease their work hours, & leave pt. care
- If unaddressed become prone to maladaptive coping
- withdrawal, denial, substance abuse, suicide
- Patients are less satisfied, less compliant, more litigious, and have longer recovery times.

The organized peer support

| 2.5% |
| 13.5% |
| 34% |
| 34% |
| 16% |

Innovators Early Adopters Early Majority Late Majority Laggards

Healing the Healer

Implementing & Practicing Peer Support

TODAY

2014 Nurse Anesthesia of Maine 2014 Maine Medical Center EMMC starting

MITSS, Boston 2002 Brigham, Boston 2005 University of Missouri, 2008

Dr. Albert Wu

How Little Things Can Make a Big Difference

“A Peer Support Program is one way forward, away from a culture of invulnerability, isolation, & shame Toward a culture that truly values a sense of shared organizational responsibility for it’s staff well-being and client safety.”


Does it have to be an “adverse event” to be impactful???
A Critical Incident

Any event that has significant emotional power to overwhelm usual coping methods.

The event has the impact of undermining a person’s sense of safety, security, or competency (CISM International).

Anticipated High Risk Situations

**Any unanticipated event involving a pediatric pt.**
- Long term care relationship coupled death/injury
- Failure to rescue or detect pt. deterioration
- First death experienced by staff member
- Event clusters in a short period of time
- Patient connected to staff member
- Staff member death or near death
- Notification of pending litigation
- Preventable harm to a patient
  - New(er) practitioners
  - Near miss incident
  - High profile cases
  - Medical error

Peer Support Role Description

<table>
<thead>
<tr>
<th>What a Peer Supporter Does</th>
<th>Peer Supporters Do NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normalizes feelings of peer</td>
<td>Participate in Quality Assurance, RCAs</td>
</tr>
<tr>
<td>Validates competence of peer</td>
<td>Offer disclosure coaching</td>
</tr>
<tr>
<td>Assesses need for professional resources</td>
<td>Deal with job performance issues</td>
</tr>
<tr>
<td>Directs peer to other resources as appropriate</td>
<td>Handle substance abuse coaching or violence prevention</td>
</tr>
<tr>
<td>Follows up with peer in the short term and long term to “check-in”</td>
<td>Offer malpractice suit support</td>
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Peer Support Distinctions

- Immediately accessible
- Completely separate from “quality” & risk management
- Absolutely confidential AND VOLUNTARY
- NO notes or records made
- “Emotional First Aid” (NOT therapy), based in CISM
- Only “peers” can be peer supporters
- Focus on feeling around the event, not the details
- Facilitates access to next level of support when needed
- NOT a debriefing
- 1:1 interactions only, no groups

Peer Support...Our Mission

- Provide education, direction, & support to those affected by a critical incident.
  - Normalize the stress reaction & encourage self-care.
  - Provide support through the recovery process.
  - Provide an “on the ground resource” able to screen & encourage providers to seek professional help when necessary.
  - Ultimate goal is to help prevent long term consequences such as burn-out, PTSD, suicide, or drug and alcohol abuse.

LEGAL CONCERNS

- Executive leadership approval
- Consult risk management & malpractice insurer
- Maine has Peer Review Law
- Plaintiff attorney will not oppose a sympathetic defendant.
  - To date no reported attempts to subpoena peer support witnesses
**Second Victim Recovery Trajectory**

(Storr et al., 2016)

- **Stage 1-3:** Impact Realization
  - Chas & Accident Response
  - Preventive反射: Reflect
  - Repetitive response
  - Stressed & involved
  - Reactions: Shock
  - Frequent use
  - Stressed & involved
  - Reactions: Shock
  - Frequency

- **Stage 4:** Ending the Enigma
  - Investigations
  - Policy Changes
  - Presentations
  - Lawyers
  - Confidence
  - End

- **Stage 5:** Obtaining Emotional First Aid
  - Drop Out
  - Suicide
  - Changing
  - Empathy
  - Trust

- **Stage 6:** Moving On
  - Relieved
  - Pre-event performance
  - Relieved

**Common Reactions to Traumatic Events**

<table>
<thead>
<tr>
<th>Psychological &amp; Emotional</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed mood</td>
<td>Difficulty sleeping/insomnia</td>
</tr>
<tr>
<td>Loss of trust</td>
<td>Trouble eating</td>
</tr>
<tr>
<td>Irritability</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Headaches</td>
</tr>
<tr>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td>Grief</td>
<td></td>
</tr>
<tr>
<td>Frustration</td>
<td></td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td></td>
</tr>
<tr>
<td>Feeling inadequate</td>
<td></td>
</tr>
<tr>
<td>Recurrent images or thoughts</td>
<td></td>
</tr>
<tr>
<td>Distress when exposed to reminders of event</td>
<td></td>
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<tr>
<td>Loss of interest or pleasure</td>
<td></td>
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</tbody>
</table>

**Common Reactions to Traumatic Events**

<table>
<thead>
<tr>
<th>Behavioral</th>
<th>Cognitive</th>
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</thead>
<tbody>
<tr>
<td>Hyperactivity or lethargy</td>
<td>Feeling numb &amp; disconnected</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>Inability to think or concentrate (thoughts feel thick &amp; scattered)</td>
</tr>
<tr>
<td>Social isolation</td>
<td>Feeling distracted</td>
</tr>
<tr>
<td>Insomnia or excess sleep</td>
<td>Hypervigilant &amp; “jumpy”</td>
</tr>
<tr>
<td>Avoidance behaviors</td>
<td></td>
</tr>
<tr>
<td>Desire to avoid things that remind you of the event (certain patients)</td>
<td></td>
</tr>
<tr>
<td>Strong desire to talk or read information about event</td>
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</tr>
</tbody>
</table>
What can I do?

Second Victims Worry....
- Patient
  - "Is the patient/family okay?"
- Me
  - "Will I be fired?"
  - "Will I lose my license?"
- Colleagues
  - "What will my colleagues think?"
  - "I'm sure they are talking about me."
  - "Will I ever be trusted again?"
- Next Step
  - "What happens next?"

Department Leaders Six Key Actions
- Connect with staff involved ASAP
- Acknowledge the incident
- Refer to peer support
- Reaffirm confidence in their abilities
- Notify staff of next steps if error
- Keep them informed
- Check on them regularly
- Don't assume they are fine
- Make accommodations when possible
- Consider calling in flex staff
- Let them know you will support them if they need to speak to EAP/counselor
- Watch for sign of distress

Structure of a Peer Support Conversation
Peer Support Interaction Steps
1. The Reach out - Introduction
2. Exploration
3. Information “Normalizing” & Coping
4. Resources and Follow-up

Basic Peer Communication
- This is Emotional First Aid, don't judge, advise, or fix....LISTEN!!!!
- Peer support is about holding a space, allow for silence
- Use “I” statements
- Maintain eye contact
- Don’t assume your experience is the same
- VERY Cautiously relate personal experiences to their situation (can come across offensive & all about you)
- Pay attention to your non-verbal cues.
- Sit, Sit, Sit

General Interaction Guidelines
- Listen and allow for silence
- Express appreciation for sharing
- Restate, paraphrase, reflect emotion, normalizing emotions
- Summarize
  - "It sounds like you are saying...
  - I can see you are upset!"
**Specific Helpful Responses**
- “I (and every clinician I know) has been involved in an adverse event, you are not alone in this.”
- Humans make errors
- “It’s common to….” “obese/lose sleep, etc.”
- “The fact that you are upset shows that you are caring & committed professional….you actually care.”
- With time, the feelings usually slowly lessen
- Perspective: “I know this is difficult, but you also remember how much good you have done….you have helped many people throughout your career.”

**PLEAS...**

**JUST SHUT UP.**

**Some “Don’ts”**
- “That’s not so bad.”
- Don’t downplay their feelings.
- “Wow, that sounds like a bad mistake. You must feel awful.”
- “Oh, I always do it this way.”
- Don’t undermine their competency or confidence.
- “What happened to me was much worse!” It’s not about you.
- Don’t take over the conversation with your own experience, but do gently share your own experience to reduce the person’s feelings of isolation or shame.

**COPING: Drawing on the Peer’s Past Experience**
- Ask them...
  - What has worked for you in the past when you are stressed?
  - Can you do more of that?
  - What can we do to help you at work?
  - Leave early, alter schedule, assignments, venue, day off
  - Who do you have for positive supports?
  - What’s your plan when you leave here?
  - Are there any extra stresses that can be eliminated, rescheduled, or deferred?
  - Are you going to be okay?

**Facilitating Resilience: Tell the Peer To…**
- Determine what you can control
  - Take control of what you can
  - Your schedule & assignments/lead
  - Eliminate unnecessary stress/expectations
  - Let go of what you cannot
  - Other People, places, and things
  - Allow the feelings to move through you
- Avoid obsessive feedback loop
  - Mindfulness body exercises
  - Keep your head where your hands and feet are
  - Meditation
  - Get out of your head and into your body
  - Do the things you enjoy
  - walk, move, exercise, journaling, yoga.
  - Move, move, move!!!

**Resources and Follow Up**
- Is an additional visit needed?
  - Provide information
    - Pamphlets or fliers (if available) on self-care & common reactions to stress
  - Articles that might be helpful - Sue Scott’s - Natural History of Second Victim Support
  - Ask if you can touch base as needed (1 day - 2 wks.)
  - Provide your contact information
- Referral to additional resources
  - Patient Relations
  - Department Leaders or Risk Management - if needs process info or schedule change
  - External Resources
    - EAP
    - Chaplaincy
    - MITSS
    - Counselor or therapist

**Scheduling a Critical Incident Stress Debriefing**
- Facilitated by EAP
- 3 or more steel affected
- Signs of Obvious distress
  - Staff returning to work on their day off following an event
  - “I just didn’t want to be alone”
  - I just couldn’t stay at my apartment”
  - Powerful emotional responses when asked about the event by coworkers
  - Anger
  - Scared and angry
  - Numbing away (bathroom, etc.)
  - General irritability with everything
  - Withdrawn, can’t get out of their own way
Putting the Pieces Back Together

- Emotional impact debriefing is NOT a system review debriefing.
- Facilitated by a certified CISM debriefing specialist
- EAP
- Other CISM resource like Acadia
- Invite EVERYONE who was INVOLVED!!
- Absolutely NO supervisors, unless directly involved
- Strict Confidentiality
- Privacy and respect for the process
- Encourage attendance by all team members

Pick a Path

- Building a Peer Support Program?
  - Material approx. 12-15 min
  - Questions

OR

- Implementation examples
  - 4 case studies approx. 15 min
  - Questions

CISM Group Debriefings

- Best practice is 24-72 hours post event
- Prior = Shock = Numb
- Unit level peer support is already activated

Building a Peer Support Program

"Look at the world around you. It may seem like an immovable, impalacable place. It is not. With the slightest push-in just the right place-it can be tipped"

When Just Knowing it Happened is too Much

- Layered CISM Debriefings May Be Indicated
  - Immediate Individual Peer Support
  - Primary debriefing for those involved
  - Secondary debriefing for those who knew the pt., but were not present at the event
  - Tertiary debriefing for those who are impacted simply by being knowing it happened

DARE TO BE A CHANGE AGENT

“Consciously or not, we participate in the creation of change or the maintenance of the status quo…”
Malcom Gladwell

- Characteristics of a change agent
  - Clear Vision
  - Patient yet persistent
  - Ask the tough questions
  - Lead by example
  - Build strong trusting relationships

- Influence what you can
  - Integrate the concepts into your life in small ways
  - Reach out to others
  - Dare to reach out when you are vulnerable
  - Do that thing you DON'T want to do
  - Start a pilot program
  - EXPECT NOTHING
Old cultural beliefs and standards
Perfectionism
"It's the job you signed up for, move on."
Stigma to reaching out for help
Fear of being ridiculed
High acuity areas have little time to integrate what has happened
Intense fear of the unknown
Fear a compromise of collegial relationships because of event
Fear of future legal woes, HIPAA, and confidentiality implications

Is your organization culturally ready for a program to provide support?
“Leaders are charged to be visionaries and change agents: that is, to see the desired future and make it happen” - Malcolm Gladwell

Consider the Culture
Providers & environments have unique support needs
- Multidisciplinary vs. Homogeneous environment
- 24/7 vs. regular Mon-Fri business hours
- Trauma call, weekends, holiday, vacations
- Every facility has a unique culture
- Small intimate group vs. Large impersonal bureaucracy
- What are the current resources at hand?
- What will the support look like & how will it be accessed?
- Peer to Peer
- Professional EAP or “Sister Institution” (i.e., Acadia)
- One on one vs. Group
- Hybrid model

Getting Started
- Who’s the owner...who has the drive and passion?
- Find an executive sponsor to break down the barriers you face
- Partnership between that person and key players.
  - Who are your champions and organizational key players?
- Where will a program be anchored?
- Create a multi-disciplinary steering team or advisory committee
  - Organizational champion, key players, and representative from each discipline including ancillary/support staff
  - Ensure sound financial support, structure, functionality, and accessibility
- Consider starting small w/ a pilot project
  - A small start is still a start

Things for Advisory Committee to Consider
- Is the organizational culture ready to support the program?
  - Integrated and functioning culture of safety
- How much will it cost and how will it be funded?
- What type of program and anchored where?
- How will you choose your peer supporter
- Who will train the peer supporter?
- How will program effectiveness be measured?
- How will it be marketed internally?
- Launching details

Be Brave and Get Started
Timing is “Almost” Everything...
Watch for that moment when the unexpected becomes possible
**Choosing Peer Supporters**

- Staff nomination is preferred
- “Who would you turn to for support after a difficult event?”
- Peer Supporter Qualities
  - Professionally respected & able to hold confidence
  - Considered to have sound judgement
  - Empathic, emotional maturity
  - Cultural awareness
  - Adequately represent gender & age
- Team should be large enough to prevent supporter burnout
- Enough to cover vacations, days off, etc.

**Qualities of a Peer Supporter**

- Do you know someone with these qualities?? Please nominate them for the Perioperative Peer Support Team!

- Empathetic
- Empathy & emotional maturity
- Cultural awareness
- Active Listening & Communication skills
- Direct to small & large steps through difficult times
- Support and self-care techniques
- Ability to maintain confidentiality

**My Story…**

- 20 years in the profession
- 8 years same job
- Dissatisfied, felt disenfranchised
- WANTED OUT!!!
- Actively looking for a new job
- Sports related injury
- Torn Achilles & sacroliliacs
- Lost main stress coping mechanism
- Physically weak & debilitated
- Rapid Wt. gain compounding sense of weakness and failure
- Pissed off
- Chronic pain syndrome
- I was “that girl” and I couldn’t stop it.

**Qualifiers: 2018 03 27**

- Everyone was fine except me
- Felt completely @ fault
- I had failed this child & mother
- Fared Shouldn’t be doing this job...And that everyone around me knew it.
- Obsessing & Ruminating
- Sense of professional weakness & isolation
- Flashbacks
- Irritable, distracted, foggy, & fatigued
- Experienced terror x1 yr. It thought of doing a child under 7

**Valentines Day 2016**

- Extremely busy Valentines day
- multiple suicide attempts, short staff, no breaks
- 14 y/o male from elsewhere
- GSW to face, attempted suicide
- No distinguishing facial features
- Unsecured airway, spontaneous breathing, concious, and following commands
- intubated in ER w/ anesthesia stand-by
- To OR for emergency trach
- Immediately transferred via life flight post-op
Pediatric Dental Rehab

- 12 y/o female (>100 pounds)
- IDDM w/ insulin pump, active cares, ? abscess
- PTSD rt parental death in hospital w/in the year
- Loud, manipulative, disruptive, combative.
- Refused versed, weight, vs., or change of clothes
- No parental control of behavior
- Staff was stressed
- turned on each other
- Ketamine dart
- to OR unconscious in street clothes
- Mother crying
- Same day group processing meeting

ACES QUESTIONS (paraphrased)

- Did a parent or adult insult or humiliate you or act in a way that made you afraid for your physically hurt?
- Did a parent or adult in the household push, grab, slap, or throw something at you, OR ever hit you so hard that you had marks?
- Did a parent or at least 5 yrs. older ever touch/fondle you, OR have you touched them in a sexual way?
- Did you often feel nobody in your family loved you or thought you were important?
- Did you often feel you did not have enough to eat, had to wear dirty clothes, & had nobody to protect you?
- Were your parents divorced or separated?
- Did a household member go to jail?
- Was a family member depressed or mentally ill or attempt suicide?
- Did you live with anyone who was alcoholic or abused drugs?
- Was your mother physically assaulted or threatened OR threatened?

Withdraw of Care in the OR

- 88y/o female for hip pinning
- End stage aortic stenosis
- Deferred discussion w/ pt. & family re: odds of survival & if case should be done or not
- Pt. requested DNR, No CPR and no Defib/cardiopulmonary
- Told the RN, “We die, have a beer for me”.
- Pt. died upon emergence
- Pt. coded upon emergence
- Withdrawal of support in OR
- Individual provider support huddle

References


Questions???